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CHR RECORDS

June 16, 1947

Dr. Harold A. Friedman
Strong Memorial Hospital
360 Crittenden Boulevard
Rochester 7, New York

Dear Dr. Friedman:

We are in receipt of your recent request for further information concerning

was admitted to the hospital on April 7, 1947 at which time her primary complaints were persistent vomiting of several days duration and weakness. With the exception of these symptoms there had been no significant change in her symptomatology since she was last seen at the Strong Memorial Hospital.

Physical examination revealed an extremely obese girl with coarse hair and flushed, phlethoric appearance. There was some blurring of the right optic disc and considerable blurring of the margins of the left optic disc. The epiglottis was easily seen and a small area of hemorrhage was seen on the anterior surface. The chest was essentially negative. The heart was enlarged to the left and the blood pressure was 210/120. The abodmen appeared negative other than extreme adiposity. Considerable kyphosis of the dorsal spine was noted. There were numerous ecchymotic areas over both lower extremities.

Admission urinalysis was as follows: Reaction acid, specific gravity 1.010, albumin 4+, white blood cells 2+ and red blood cells 4+. Admission blood count was as follows: Hemoglobin 75%, RBC 3,640,000, and WBC 18,050 with 11 stabs, 78 segmented, and 11 lymphocytes. Sedimentation rate was 37. NPN was 59. A blood glucose 100. Blood chlorides 450, serum calcium was 8.5 and blood phosphorus 4.0 mg%.

On only symptomatic treatment, the vomiting ceased almost immediately.

After several days in the hospital, however, the patient edeveloped marked listlessness and weakness. There was frequent urination of small amounts and considerable dyspnea developed. There symptoms persisted until the patient expired on April 29, 1947.

On April 16th, a glucose tolerance test was made, the results of which were as follows: Fasting specimen 95 mg%., ½ hour after glucose 145 mg%., 1 hour after glucose 165 mg%., 2 hours after glucose 170 mg%., 3 hours after glucose 150 mg%.

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Repeated urinalysis showed persistent large quantities of blood and albumin. By April 18th the NPN had increased to 117 mg% and on April 23rd the NPN was 168 and creatinine 6.3.

In view of these findings it was decided that the patient's ultimate death was due to renal failure and uremia.

During the time the patient was in the hospital, a chest x-ray was made which showed moderate cardiac hypertrophy, transverse apical diameter being 16 cm. with an intrathoracic of 27.5 cm. Radiographs of the skull showed expansion of the sellatursica. AP diameter was 14 cm. and sella appeared deeper than average. Posterior clinoid showed moderate erosion.

I trust this information will meet the requirements. If there is any additional data I can supply, I will be glad to do so on request.

Very truly, yours,

P. A. BURGESON, M.D.